Indigenous Factors Relevant for Safe Birth in Cultural Safety Among Nancue ñomndaa Communities in Guerrero, Mexico. Protocol of a Study Based on Conversations

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Abstract

Culturally unsafe approaches to the study of Indigenous birthing systems in the South of Mexico perpetuate the dominance of Western views in the shaping of health care systems; thus, reducing their cultural pertinence and quality. In this protocol, we propose a methodology to understand the most relevant factors associated with safe birth according to the knowledge of traditional Indigenous midwives. We propose to use conversations as a methodology to promote intercultural dialogue. Conversations recognise mutual interaction and construction of meaning, thus allowing for Western and Indigenous practitioners to interchange knowledge and mutually enrich one another. Three experienced traditional midwives will participate in one-on-one conversations with an indigenous researcher. They will provide the first level of understanding on the meaning of relevant factors for safe birth in their communities. A group of non-indigenous Academic researchers will participate in the process, sharing their knowledge about the issue and supporting the analysis process. These initial results will be discussed in a group conversation with traditional midwives and their apprentices to confirm the content, suggest additional elements and share the knowledge amongst each other. This study is part of a larger effort to support and strengthen the practices of traditional midwives in these communities.

Keywords

Intercultural dialogue, Safe motherhood, Indigenous health, Traditional birthing systems

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Introduction

Acculturation, with loss of identity and traditions, has had profound effects on health and health care in indigenous communities (King, Smith, & Gracey, 2009). Historically, power imbalances associated with colonisation have been accompanied by disrespect, imposition of external values, and marginalisation of traditional health systems and their practitioners (Sam & Berry, 2016).

This historical process has led to the institutionalisation of Western birthing practices based on biomedicine (Jordan, 1989; Sesia, 1996). However, this is an incomplete process in many rural and marginalised areas where a poor application of Western principles have not achieved the expected benefits (Chalmers, 1997; Mills, 2017). Viewed alongside the loss of identity and traditions, health actions derived from Western biomedical perspectives, such as training birth attendants, perpetuate a power asymmetry and ignore the cultural content of indigenous groups (Cameron, Andersson, McDowell, & Ledogar, 2010). In Guerrero, one consequence of this situation is that indigenous women face a heavier burden of poor maternal health (Meneses, Pelcastre, & Vega, 2018).

The present qualitative protocol is part of an ongoing partnership with traditional midwives and local academics in Guerrero State, Mexico. The goal of this partnership is to understand the role of traditional midwives and the impact that they can have in safe birth and cultural safety (Sarmiento, Paredes-Solís, Andersson, & Cockcroft, 2018). In this context, we used Fuzzy Cognitive Maps (FCM) (Giles, Haas, Šajna, & Findlay, 2008) to describe traditional midwives' perspective on what factors promote or hinder safe birth in their communities.

We propose a methodology to describe four factors that were identified in the FCMs as the most relevant: three traditional diseases (*Espanto*, *Coraje*, and *Frio del cuerpo*) and traditional self-care practices. These factors belong to the traditional knowledge of the participant communities (International Council of Science, 2002), particularly as components of a birthing system.

A birthing system is defined as an internally consistent set of practices and concepts that are designed to manage the physical and social aspects of parturition in a way that makes sense in a particular cultural context (Jordan & Davis-Floyd, 1993).

The understanding of these factors requires an in depth look into elements of Indigenous culture and their particular views of health. One approach to this is ethnography. In the context of health, it has produced the notion of culture-bound syndromes, “defined as sets of symptoms and signs unique to specific regions or countries around the world. They are understood as characteristic responses to a variety of pathogenic agents and are explained in the context of beliefs, traditions, and moral or religious perspectives from their societies of origin.” (Alarcón, 2015).

However, this approach represents a partial view of the issue (United Nations Educational Cultural and Scientific Organization, 2009), mostly dominated by applying the Western-based categories to interpret the phenomenon under study. This is a culturally unsafe approach to our understanding (Cameron et al., 2010), where researchers unilaterally define the meaning of these events, for example by reducing them to beliefs. This protocol suggests a different approach based on intercultural dialogue (Eberhard, 2008).

Aim and objectives

Further describe and characterise four factors that traditional midwives from the *Nancue ñomndaa* group identified as the most relevant diseases (*Espanto*, *Coraje*, and *Frio del cuerpo*) and self-care practices influencing safe birth in their communities. An explicit intention is to communicate this information amongst younger traditional midwives and to Western academics; thus, fostering cultural continuity and intercultural dialogue.

Methods

Settings

We are working with communities belonging to the *Nancue ñomndaa* indigenous groups in the municipality of Xochistlahuaca, located in the southern State of Guerrero. These groups subsist mainly on migrant labour, small-scale agriculture and cattle. They still use their original language but live in a transitional process between traditional and Western ways of life.

Conversations

This protocol applies the intercultural dialogue approach (Ganesh & Holmes, 2011) that allows for ‘two-eyed seeing’ (Hovey, Delormier, McComber, Lévesque, & Martin, 2017). Therefore, we propose to use conversations between Western researchers and traditional midwives (Hovey & Apelian, 2014) and follow the principles of philosophical hermeneutics to collaboratively make sense of traditional concepts (Eberhard, 2008). In the practice, the dialogic approach also intends to generate a mutually beneficial interchange of information that goes beyond the instrumental extraction of information from the participants, typical of interviews.

Some authors identify conversations as interviews that benefit from horizontal relationships between participants and the informality of everyday talks (Roulston, 2008). And Hovey highlighted additional benefits in terms of mutual understanding and establishment of a culturally safe environment (Hovey et al., 2017). Conversations allow the construction of relationships that are fundamental for

participatory research; the etymology of the word ‘conversations’ describes a way of being with others (Czarniawska-Joerges, 1998).

Conversations demand an initial level of trust between conversationalists and emulate spontaneous encounter. This spontaneous tone requires a certain level of skill from the researcher to simultaneously maintain the purpose of the conversation (Holstein & Gubrium, 1995; Jordan & Davis-Floyd, 1993, p. 102). A history of several years of collaboration with participating traditional midwives facilitates the application of this methodology.

Participants

A group of thirteen traditional midwives and their apprentices who have been engaged in a collaborative project since 2015 (Sarmiento et al., 2018). They also participated in the session to draw the FCMs in November 2016. The traditional midwives will receive an economic compensation to cover transportation and the time invested in the activities.

Based on previous knowledge, the researchers will identify a purposive sample of the three most knowledgeable *Nancue ñomndaa* traditional midwives for the one-on-one conversations (described below). Given the extent of the conversations, having more than three of them will be unfeasible for this study. The criteria to identify these midwives are: the level of recognition from their communities and their age (assuming that the older have stronger links with the traditional knowledge). An additional criterion to select the three participants in this group will be the accessibility to their houses since some of the most traditional tend to live in remote rural areas. We will document which traditional midwives were excluded for accessibility reasons, to guarantee the transferability of our study (Shenton, 2004). Another exclusion factor is if one of them decides not to participate. In this case, the researchers will select another candidate from the list and document this decision.

The researcher in charge of conducting the conversations (Abraham De Jesús-García) is a general practitioner with a Master of Science degree in Medical Sciences. He belongs to the *Nancue ñomndaa* group. He is fluent in the local language as well as in Spanish. He coordinated the work in Xochistlahuaca since 2008 to recover the traditional indigenous health systems. In this position he has built strong relationships of trust with the traditional midwives. Abraham is a private practitioner in Xochistlahuaca, providing consultation in accordance with Western standards. The rest of the researchers (IS, GZ, SPS, NA) have extensive experience in intercultural health promotion, training in health sciences (three of them are physicians), and in epidemiology (with an emphasis on participatory research). All of them have a history of advocacy for the recovery of traditional knowledge in Colombia, Mexico and Canada.

Conversations

The conversations will take place in two consecutive scenarios. First, Abraham De Jesús-García, will conduct one-on-one conversations with senior traditional midwives and one researcher about each of the concepts/factors under study. And second, a group conversation to foster interaction and knowledge sharing among traditional midwives and their apprentices.

One-on-one conversations. We will have three one-on-one conversations with senior traditional midwives. We have not defined time limits, and conversations might take place in more than one session until participants decide they have completed the objective of the activity. The interviews will take place at the house of the traditional midwife or wherever she feels more comfortable.

Before each conversation, the researcher will follow a standard procedure to guarantee informed consent. He will use the local language during the whole session because we expect a limited use of Spanish among the eldest traditional midwives.

Two general questions will start the conversation for each of the factors under study: i) Can you please explain to me what this means [the factor under study]? And ii) Can you please provide me with an example or a story of someone to understand the effect of [the factor under study]?

During the conversation, the researcher will share with the midwives his understanding of the issue, if any, and will prompt additional questions until both (researcher and traditional midwife) think the topic is fully covered. However, the conversation can end at any point if one of the participants feels any kind of discomfort or just does not want to continue.

We expect to study two kinds of factors: (1) diseases and (2) traditional self-care practices. For the former, the conversation will attempt to cover at least these additional specific questions: How can we recognise this factor? What are the causes? What are the treatments or responses? How can we prevent its onset?

For the self-care practices, the conversation will cover at least: A detailed description of the protective action; What is the consequence of not following this protective action? Why is this protective action important, if at all?

The history of collaboration and friendship with these women makes us confident that recording the conversations will not hinder communication. The decision to record the sessions is based on Abraham's request for not having to take notes at the same time he is in the conversation. Given the level of intimacy that we expect during the interaction, we think that having the support form a reporter could be disruptive. Data collection started in March 2019 after the protocol received ethical approval.

Iterative process of adjustment. Once the first conversation has finished, a research assistant fluent in the local language and Spanish will translate and transcribe the content of the recording. All of the researchers will review the transcription and prompt for additional questions. Ivan Sarmiento, will coordinate a final list of additional questions for the first conversation and have suggestions for Abraham to have in mind during the second conversation. This procedure will take place again with the subsequent sessions. If the researchers identify questions that need additional discussion after all the one-on-one conversations have finished, these questions will be raised during the group conversation.

Data analysis. In our methodology, rapport building happens throughout the encounter, and it is well recognized that the content and meaning of the conversation implies a complex process of decision making for action and interaction (Goodwin & Heritage, 1990). This is the field of conversational analysis, however, in this study we will focus on the content more than on the discursive aspect. Also of interest, we are limited because the conversations will happen in an indigenous language and developing the tools for this type of analysis is beyond our objectives.

Using a predefined format based on the questions for risk and protective factors (described above), Ivan Sarmiento will summarise the responses from the midwives using an inductive thematic analysis. He will keep a record of the quotes from the interviews in each category. If relevant content does not fit into the categories, he will take note of this for further discussion with the other researchers. This first summary will use Spanish. The other researchers will read the transcriptions and suggest adjustments until a final version is agreed upon.

Records with the interviews will remain in possession of the research team at all times. If sensitive information is disclosed, researchers will increase the security measures to guarantee confidentiality.

Group conversation. Following the format of focus groups (Given, 2008; Schwandt, 2007), we will gather a group of 13 traditional midwives and their apprentices. The three traditional midwives involved in the one-on-one conversations will also participate. Before the conversation starts, we will ask for informed consent using a predefined script.

Abraham will facilitate the session using the local language at all times. One research assistant fluent in the local language and in Spanish will take notes. The conversation will start with an explanation of the research procedure, reminding the participants of the previous activities on FCM. We will present the table summarising the data from the one-on-one conversations.

He will ask the three traditional midwives to corroborate whether the content of the table represents their knowledge and what adjustments they think are needed (member checking strategy) (Birt, Scott, Cavers, Campbell, & Walter, 2016). Then, he will ask the other participants whether they

knew of this information and if they have additional information to contribute. If participants provide information on new elements, the facilitator will ask them for examples or stories to illustrate this knowledge.

The session will end when all of the participants feel that they have completely described the relevant aspects of each factor. The member checking process for the group conversation will consist in a final summary at the end of the session to double check the accuracy of the adjustments.

Quality assurance: Trustworthiness

Following the criteria proposed by Guba we attempt to describe the expected level of validity and reliability of our study (Guba, 1981).

Credibility (how congruent are the findings with the reality?)(Shenton, 2004): we have adopted a method clearly defined in a protocol with predefined rules for decision making. This methodology has been successfully applied in other studies (Hovey et al., 2017; Sarmiento, Zuluaga, & Andersson, 2016). Traditional midwives are committed to the process of intercultural dialogue and open to share their knowledge. The sampling strategy will involve the traditional practitioners that communities recognize as most knowledgeable. Although we will not confirm the veracity of the stories that midwives share, we expect that sharing these stories in a group will increase their reliability; in practice, group conversations constitute a way to triangulate findings. We will report if contradictory information arises.

Transferability (extent to which results apply to other situations): our aim is to inform the views from the *Nancue ñomndaa* group. An in-depth description of each factor will allow readers to compare the similarities of these factors with those in other contexts.

Dependability (if the work were repeated in the same context in a similar way, same results would appear): participating traditional midwives hold a high level of recognition in their communities. Any study covering the issue would need to include the same group of traditional midwives.

Confirmability (objectivity): conversations are a form of interaction in which participants generate intersubjective understanding of an issue. We have also made explicit the intentions of this participatory study. The level of intimacy and confidence that our study expects would not be possible without the previous experiences and common intentions of participants and researchers. The final results table will also include the understanding of researchers to make their contributions clear (Given, 2008).

Discussion

In our attempt to further extend intercultural dialogue between traditional and Western understanding of safe birth, we propose a methodology that avoids interpreting risk and protective

factors described by traditional midwives as merely beliefs from other cultural contexts. Also, we recognize that these factors cannot be simply translated using Western names to describe their meaning.

Our approach is to describe these factors in what can be depicted as the intersection of two circles, one representing the traditional knowledge of the indigenous communities and the other representing the medical understanding of Western researchers. However, these Western researchers share a unique characteristic of openness to the dialogue with the traditional knowledge.

We expect that this study will overcome reductionism and stereotypes, thus attempting to broaden a mutual understanding of safe birth in cultural safety.

Declarations

Ethics

Community assemblies representing the indigenous peoples involved in the trial approved the project between January and February 2015. The Institutional Review Board (IRB) at McGill's Faculty of Medicine approved this protocol in February 2019 (A06-B28-17B).

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Conflict of interests

Authors do not declare conflicts of interests

Publication policy

Traditional midwives reiterated their authorization to disseminate research results in July 2018. However, at the end of the group conversations researchers will acquire the permission of participants to publish the results.

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